The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) includes several provisions to enhance beneficiary access to quality health care services and improve provider payments in rural areas.

Hospitals:

- **Standardized amount**. The Act equalizes the urban and rural "standardized amounts" under Medicare's prospective payment system for inpatient hospital services. Currently, Medicare has two different operating base payments for inpatient hospital services—one for hospitals located in large urban areas and another, smaller payment for hospitals located in rural and small urban areas. This provision establishes a single base payment, or standardized amount, for hospitals in all areas in the 50 states, the District of Columbia, and Puerto Rico, starting in FY 2004.

- **Labor-Share**. The Act revises the labor-related share of the wage index used in Medicare's prospective payment system for inpatient hospital services. It reduces the labor-related share of the wage index to 62 percent (currently it is 71.1 percent), unless such revision would result in lower payments. The labor share is an estimate of the national average proportion of hospitals' costs associated with inputs that are directly or indirectly affected by local wage levels. Many rural hospitals argue that, because their local wage levels are low, they are adversely affected by a high labor-related share.

- **Disproportionate Share**. The Act modifies Medicare's payments for those hospitals that furnish care to a disproportionate share of low-income and uninsured patients. Currently, the disproportionate share hospital adjustment paid to rural and small urban hospitals is capped at 5.25 percent. The Act increases the rural and small urban cap to 12 percent.

- **Outpatient PPS**. The Act allows sole community hospitals and small rural hospitals to be held harmless under the outpatient hospital prospective payment system for 2 years.

- **Low Volume Hospitals**. The Act establishes a graduated adjustment/add-on payment for low-volume hospitals. Eligible hospitals are those that are located more than 25 miles away from another hospital and have less than 800 discharges in a given year. The adjustment is to be determined by the Secretary based on the relationship between cost-per-case and discharges in low-volume hospitals. The total adjustment may not exceed 25 percent of the otherwise applicable prospective payment rate.

- **Residencies**. The Act redistributes resident positions from hospitals that have not met their resident cap over a defined period of time. Hospitals located in rural areas are given top priority for receiving these redistributed resident positions.

- **Medicaid DSH.** The Act includes a provision for 10 extremely low Medicaid DSH states (Arkansas, Idaho, Iowa, Montana, Nebraska, North Dakota, South Dakota, Utah, Virginia, Wisconsin) that will receive an enhanced allotment under the agreement. Allotments for these 10 states would be increased by 16 percent for each of five years (FY 2004 - FY 2008) at which point allotment levels would be those for the previous year increased by the CPI-U.

Physicians:

- **Bonus Payments**. The Act modifies the Medicare Incentive Payment Program, which provides 10 percent bonus payments to physicians in Health Professional Shortage Areas. The Act builds upon this existing program, and adds a new program for physicians serving beneficiaries in physician scarcity counties. Under this new program, physicians would receive a 5 percent bonus payment for providing services in newly defined shortage areas.

- **Geographic Adjustment.** The Act modifies the geographic adjustment for physician payments. The geographic adjustment is in place to reflect the regional differences in the costs of the various inputs necessary to furnish a physician service. These inputs are physician work, practice expense, and malpractice. The Act establishes a floor on one of the three geographic adjustments—the work component. In so doing, it increases the payments to physicians in rural areas by raising their adjustment to the newly established floor.

Critical Access Hospitals:

- **Payment.** The Act makes several modifications to the Critical Access Hospital Program. This program, created by Congress in the Balanced Budget Act of 1997, is designed to support limited-service hospitals located in rural areas. Medicare pays critical access hospitals on the basis of their current Medicare-allowable costs. The Act increases critical access hospital payments to 101 percent of reasonable costs and extends cost-based reimbursement to additional on-call emergency care providers, providing additional dollars to these rural hospitals. The Act also reauthorizes the Medicare Hospital Flexibility (FLEX) Program, expanding this important source of grant funding for small rural hospitals.

- **Status**. The Act removes barriers for hospitals that are seeking critical access hospital status, while easing some of the requirements that are in place for existing critical access hospitals. The Act allows critical access hospitals to use up to 25 beds for acute care (currently, it is limited to 15 beds). This allows greater flexibility to critical access hospitals. The Act also authorizes periodic interim payments, allowing critical access hospitals to receive payments every 2 weeks, as is currently the case

for eligible hospitals, skilled nursing facilities, and hospices. The Act allows critical access hospitals to establish psychiatric and rehabilitation distinct part units with up to 10 beds each. In addition, the Act limits the state waiver of the 35-mile rule and facilities designated as critical access hospitals before January 1, 2006 are grandfathered in.

Other Provisions:

- **Home Health**. The Act increases payments to home health agencies by 5 percent for services furnished in rural areas.

- **Telemedicine**. The Act extends the current telemedicine demonstration by 4 additional years, and authorizes an additional $30 million in funding.

- **Telehealth Originating Sites**. The Act includes an evaluation under which skilled nursing facilities are treated as originating sites for telehealth services. This provision is to assist with determining if SNFs should be included in the list of originating telehealth sites. The provision also authorizes the expansion of SNFs as telehealth originating sites if the Secretary concludes it is advisable to do so.

- **Ambulance**. The Act increases payment to ambulance providers and suppliers furnishing services in rural areas, directing the Secretary to increase payments for ambulance trips that originate in rural areas with a particularly low population density. The Act also increases payments by 2 percent for rural ground ambulance services and 1 percent for non-rural ground ambulance services. In addition, the Act establishes an alternate fee schedule phase-in formula for some providers based on a blend of the national fee schedule and a regional fee schedule, to ease the current transition to the national fee schedule. The Act also increases payment for ground ambulance trips that are longer than 50 miles. The Act also establishes a presumption of medical necessity for certain rural air ambulance services.

- **Hospice**. The Act allows nurse practitioners to act as the attending physician for a beneficiary that elects hospice. Nurse practitioners often play a central role in furnishing care in rural areas. This provision allows them to continue to serve their patients who elect hospice care.

- **Lab Tests**. The Act establishes reasonable cost payment for clinical laboratory tests furnished by certain rural hospitals as part of their outpatient services, providing additional dollars to these rural hospitals.

- **Rural Community Hospitals**. The Act establishes a 5-year demonstration to test the advisability and feasibility of establishing rural community hospitals (RCHs).

- **Frontier Extended Stay Clinics**. The Act authorizes a new demonstration project under which frontier extended stay clinics in isolated rural areas are treated as providers of items and services under the Medicare program.

- **Exclusions from SNF PPS**. The Act clarifies that certain professional services provided by individuals affiliated with Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) are excluded from the SNF PPS, in the same manner as such services would have been excluded if provided by an individual not affiliated with an RHC or FQHC. This includes the services of physicians, nurse practitioners, physician assistants and clinical psychologists.

- **Office of Rural Health Policy Improvements**. The Act expands the list of explicit responsibilities of the Office to include administering grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas.

- **Sole Community Hospitals**. The Act permits hospitals with missing cost reports to have Sole Community Hospital (SCH) status, meaning they are not denied a SCH application based on unavailable cost report data due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, as long as data are available for at least one applicable base cost reporting period.

- **MedPAC Study**. The Act directs the Medicare Payment Advisory Commission (MedPAC) to conduct a study analyzing the effect on total payments, growth in costs, capital spending, and such other payment effects of certain rural sections of the bill. The sections of the bill MedPAC is directed to study include the following: equalizing the urban and rural standardized amount (Sec. 401); establishing enhanced DSH payments for hospitals with fewer than 100 beds (Sec. 402); adjusting the labor-related share of the hospital wage index (Sec. 403); more frequently updating the weights used in the hospital market basket (Sec. 404); making improvements to the critical access hospital (CAH) program (Sec. 405); adding an adjustment for low-volume hospitals (Sec. 406); extending the 2-year hold harmless provisions for small rural hospitals and sole community hospitals under the prospective payment system for hospital outpatient department services (Sec. 411); establishing cost-based reimbursement for certain clinical diagnostic laboratory tests to hospital outpatients in certain rural areas (Sec. 416); and creating an out-bound commuting wage adjustment reclassification for hospitals (Sec. 505).